NEMLUVIO® Enrollment Form

Fax your completed enrollment form to your preferred network specialty pharmacy.

Network Specialty Pharmacies

NEMLUVIO® (nemolizumab-ilto) is available through a limited distribution network of specialty pharmacies. Our specialty pharmacy network is contracted to provide enhanced service offerings, ensuring that you and your patients are supported throughout the entire NEMLUVIO patient journey. **Please have your patient scan the QR code of your preferred network specialty pharmacy to save their contact information to their address book.**

AcariaHealth
Phone: 800-511-5144
Fax: 877-541-1503

Accredo Health Group, Inc.
Phone: 866-839-2162
Fax: 866-531-1025

Amber Specialty Pharmacy
Phone: 888-370-1724
Fax: 877-645-7514

BioPlus Specialty Pharmacy
Phone: 888-292-0744
Fax: 800-269-5493

Blue Sky Specialty Pharmacy
Phone: 866-822-0103
Fax: 833-898-3992

CenterWell Specialty Pharmacy
Phone: 800-486-2668
Fax: 877-405-7940

CVS Specialty
Phone: 800-237-2767
Fax: 800-323-2445

Kroger Specialty Pharmacy
Phone: 888-355-4191
Fax: 888-355-4192

Lumicera Health Services
Phone: 855-847-3553
Fax: 855-847-3558

Optum Specialty
Phone: 855-427-4682
Fax: 877-342-4596

Senderra Pharmacy
Phone: 855-460-7928
Fax: 888-777-5645

Walgreens Specialty Pharmacy
Phone: 888-347-3416
Fax: 877-231-8302

We'll be calling your patient. If we are unable to reach them, we will leave a voicemail message. Please encourage them to check their messages regularly.

Give this page to your NEMLUVIO patient.

Please see full prescribing information at www.nemluvio.com.

US-NMO-2400560 (12/24)

nemluvio™ (nemolizumab-ilto) for injection

Please select your preferred Specialty Pharmacy

☐ Already sent to Specialty Pharmacy?

☐ AcariaHealth Fax: 877-541-1503
☐ Accredo Health Group, Inc. Fax: 866-531-1025
☐ Amber Specialty Pharmacy Fax: 877-645-7514
☐ BioPlus Specialty Pharmacy Fax: 800-269-5493
☐ Blue Sky Specialty Pharmacy Fax: 833-898-3992
☐ CenterWell Specialty Pharmacy Fax: 877-405-7940
☐ CVS Specialty Fax: 800-323-2445
☐ Kroger Specialty Pharmacy Fax: 888-355-4192
☐ Lumicera Health Services Fax: 855-847-3558
☐ Optum Specialty Fax: 877-342-4596
☐ Senderra Fax: 888-777-5645
☐ Walgreens Specialty Pharmacy Fax: 877-231-8302

PLEASE REMEMBER

Complete the ENTIRE form to avoid any delays and fax to your Preferred Network Specialty Pharmacy.

Attach front and back of insurance card. An incomplete enrollment form may delay the start of treatment.

☐ **No insurance**
☐ **Copy of insurance card attached**

BIN ____ PCN ____ Group ____

PLEASE REMEMBER

1 Patient Information

To be fully completed by the healthcare provider and the patient or legal guardian before leaving the office. For information about how your information will be used, please see terms and conditions. By receiving services through GPS (Galderma Patient Services) for NEMLUVIO™ (nemolizumab-ilto), patient accepts all terms and conditions of the GPS for NEMLUVIO programs on page 6.

First Name ____ Middle Initial ____ Last Name ____ Email ____ Phone Number ____ *Cell Phone (preferred); Home Phone (optional)* Best Time to Contact ____

Address (No PO Box) ____ Sex: ☐ Male ☐ Female Date of Birth (MMDDYYYY) ___/___/___

Preferred Language:
☐ English
☐ Spanish
☐ Other: ____

City ____ State ____ Zip ____ Guardian First Name ____ *If patient is otherwise under the care of a guardian* Guardian Last Name ____ Guardian Relationship ____

Patient Authorization and Additional Consents

By signing below, I acknowledge I have read and agree with the Patient Authorization on page 5, and that my personal health information will be collected, used, and disclosed to provide services in the GPS for NEMLUVIO Program consistent with the terms and conditions of the program. I know that I can withdraw my consent by contacting GPS for NEMLUVIO.

SIGN & DATE

Patient/Legal Guardian Signature ____ If not patient, relationship to patient ____ Date of Signature (MMDDYYYY) ___/___/___

☐ **For manufacturer and reimbursement support, I consent to the Galderma Communications Consent, found on page 5.**

☐ **I consent to receiving Text Messages per the consent on page 5.**

2 Provider Information

☐ Allergist ☐ Dermatologist ☐ Immunologist ☐ Other: ____

Full Name ____ HCP Title ____ Practice Name / Affiliation ____ Office Contact Name ____

Address ____ Supervising Physician *If applicable* ____ Office Fax ____ Office Contact Phone ____

City ____ State ____ Zip ____ NPI Number ____ Provider / Office Email ____

3 Clinical Information

To be completed by the HCP

Please select all previous treatments tried, failed, or patient is intolerant to. Be sure to include clinic notes to support your selection(s) for payers' prior authorizations.

☐ Topical Corticosteroid ☐ Topical Calcineurin Inhibitor ☐ Other Topical (e.g., Eucrisa, Opzelura, Zoryve, etc.) ☐ Immunosuppressant (e.g., methotrexate, cyclosporine, etc.)

☐ Oral Corticosteroid (e.g., prednisone, etc.) ☐ Biologics (e.g., Dupixent, Adbry, etc.) ☐ Oral JAK Inhibitors (e.g., Cibinqo etc.)

Concurrent Medications ____

Known Drug Allergies ____ ☐ NKDA

Atopic Dermatitis

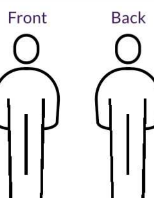
Diagnosis:

☐ L20.9 Atopic dermatitis, unspecified
☐ L20.89 Other atopic dermatitis
☐ Other ICD-10-CM code ____

Investigator's Global Assessment Score (0-4) ____

Body Surface Area % ____ ☐ If <10% BSA; involvement of sensitive areas such as palms of hands, soles of feet, groin etc.

Affected Areas



Prurigo Nodularis

Diagnosis:

☐ L28.1 Prurigo nodularis

☐ For PN, patient has >20 nodules

Please see full prescribing information at www.nemluvio.com.

nemluvio™
(nemolizumab-ilto) for injection

Patient & Prescriber Information (all fields required)

Patient First Name | Middle Initial | Patient Last Name | Date of Birth (MMDDYYYY) / /

Prescriber Name | Prescriber Address | City | State | Zip

NPI # | Prescriber State License # | Prescriber Phone Number | Prescriber Fax Number

4 Prescription Information

Prurigo Nodularis

Weight (required):

☐ lb. ☐ kg

Did this patient start NEMLUVIO on a sample?

☐ Yes ☐ No If yes, date sample product provided: / /

Send dose to (as allowable by law):

☐ HCP Address ☐ Patient's Home

Network Specialty Pharmacy Prescription
NEMLUVIO 30 mg/0.49mL single dose dual chamber pen (NDC 00299-6220-15)

Loading Dose:

☐ No, patient already on therapy

☐ **Yes, two 30mg/0.49mL pens (60mg);**
SIG: Inject contents of 2 pens (60mg), subcutaneously at week 0.
Dispense Qty: 2 pens

Maintenance Dose:

☐ **30 mg/0.49mL pen;**
SIG: Inject contents of 1 pen (30mg), subcutaneously every 4 weeks.
Dispense Qty: 1 pen Refills: ☐ 12, or ____

☐ **For patients > or = 90 kg/198.4 lb., two 30mg/0.49mL pens (60mg);**
SIG: Inject contents of 2 pens (60mg), subcutaneously every 4 weeks.
Dispense Qty: 2 pens Refills: ☐ 12, or ____

Prescriber Attestation

Prescriber must authorize these prescriptions and instructions by signing at the end of this section.

As the prescriber, I certify that NEMLUVIO is medically necessary for an FDA-approved indication for the previously identified patient and the information on this form is accurate to the best of my knowledge. I have reviewed the current full Prescribing Information for NEMLUVIO. I certify that I have obtained all necessary authorizations and consents as required by federal and state laws including HIPAA to disclose to Galderma, patient information including to facilitate insurance coverage for the product, initiating/dispensing therapy, and administering GPS for NEMLUVIO. I authorize Galderma and its affiliates, business partners, and agents to forward this prescription to the appropriate dispensing pharmacies, and I will comply with my state-specific prescription requirements, such as e-prescribing, state specific prescription forms, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

SIGN & DATE

Prescriber Signature
(Dispense as Written/Brand Medically Necessary)

Date of Signature (MMDDYYYY) / /

SIGN

Prescriber Signature
(Substitution Permissible)

Quick Start or Other GPS for NEMLUVIO Free Goods Program
NEMLUVIO 30 mg/0.49mL single dose dual chamber pen (NDC 00299-6220-15)

Loading Dose:

☐ No, patient already on therapy

☐ **Yes, two 30mg/0.49mL pens (60mg);**
SIG: Inject contents of 2 pens (60mg), subcutaneously at week 0.
Dispense Qty: 2 pens

Maintenance Dose:

☐ **30 mg/0.49mL pen;**
SIG: Inject contents of 1 pen (30mg), subcutaneously every 4 weeks.
Dispense Qty: 1 pen Refills: ☐ 12, or ____

☐ **For patients > or = 90 kg/198.4 lb., two 30mg/0.49mL pens (60mg);**
SIG: Inject contents of 2 pens (60mg), subcutaneously every 4 weeks.
Dispense Qty: 2 pens Refills: ☐ 12, or ____

Prescriber Attestation

Prescriber must authorize these prescriptions and instructions by signing at the end of this section.

I certify that any medication received will be used only for the patient named on this form and will not be offered for sale, trade, or barter. Furthermore, no claim for reimbursement will be submitted concerning this medication, nor will any medication be returned for credit. I acknowledge that this program is exclusively for purposes of patient care and not for remuneration of any sort. I understand that Galderma may revise, change, or terminate programs at any time without notice.

SIGN & DATE

Prescriber Signature
(Dispense as Written/Brand Medically Necessary)

Date of Signature (MMDDYYYY) / /

SIGN

Prescriber Signature
(Substitution Permissible)

Please see full prescribing information at www.nemluvio.com.

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Patient & Prescriber Information (all fields required)

Patient First Name ____ Middle Initial ____ Patient Last Name ____ Date of Birth (MMDDYYYY) __/__/____

Prescriber Name ____ Prescriber Address ____ City ____ State ____ Zip ____

NPI # ____ Prescriber State License # ____ Prescriber Phone Number ____ Prescriber Fax Number ____

4 Prescription Information

Atopic Dermatitis

Did this patient start NEMLUVIO on a sample?

☐ Yes ☐ No If yes, date sample product provided: __/__/____

Send dose to (as allowable by law):

☐ HCP Address ☐ Patient's Home

Network Specialty Pharmacy Prescription
NEMLUVIO 30 mg/0.49mL single dose dual chamber pen (NDC 00299-6220-15)

Loading Dose:

☐ No, patient already on therapy

☐ **Yes, two 30mg/0.49mL pens (60mg);**
Sig: Inject contents of 2 pens (60mg), subcutaneously at week 0.
Dispense Qty: 2 pens

Maintenance Dose:

☐ **30 mg/0.49mL pen;**
SIG: Inject contents of 1 pen (30mg), subcutaneously every 4 weeks.
Dispense Qty: 1 pen Refills: ☐ 12, or ____

Prescriber Attestation

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As the prescriber, I certify that NEMLUVIO is medically necessary for an FDA-approved indication for the previously identified patient and the information on this form is accurate to the best of my knowledge. I have reviewed the current full Prescribing Information for NEMLUVIO. I certify that I have obtained all necessary authorizations and consents as required by federal and state laws including HIPAA to disclose to Galderma, patient information including to facilitate insurance coverage for the product, initiating/dispensing therapy, and administering GPS for NEMLUVIO. I authorize Galderma and its affiliates, business partners, and agents to forward this prescription to the appropriate dispensing pharmacies, and I will comply with my state-specific prescription requirements, such as e-prescribing, state specific prescription forms, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

SIGN & DATE ____ __/__/____

Prescriber Signature
(Dispense as Written/Brand Medically Necessary)

Date of Signature (MMDDYYYY)

SIGN ____

Prescriber Signature
(Substitution Permissible)

Quick Start or Other GPS for NEMLUVIO Free Goods Program
NEMLUVIO 30 mg/0.49mL single dose dual chamber pen (NDC 00299-6220-15)

Loading Dose:

☐ No, patient already on therapy

☐ **Yes, two 30mg/0.49mL pens (60mg);**
Sig: Inject contents of 2 pens (60mg), subcutaneously at week 0.
Dispense Qty: 2 pens

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I certify that any medication received will be used only for the patient named on this form and will not be offered for sale, trade, or barter. Furthermore, no claim for reimbursement will be submitted concerning this medication, nor will any medication be returned for credit. I acknowledge that this program is exclusively for purposes of patient care and not for remuneration of any sort. I understand that Galderma may revise, change, or terminate programs at any time without notice.

SIGN & DATE ____ __/__/____

Prescriber Signature
(Dispense as Written/Brand Medically Necessary)

Date of Signature (MMDDYYYY)

SIGN ____

Prescriber Signature
(Substitution Permissible)

Please see full prescribing information at www.nemluvio.com.

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Patient Authorization

I acknowledge that some healthcare providers, pharmacies and health insurers, and their service providers (collectively, "Providers") may use and disclose my information related to health insurance benefits, medical condition, treatment, and prescription details ("Health Information") and identifying information about me including information such as my name, address, and date of birth ("Identifying Information") with other Providers under my other existing HIPAA authorizations.

By signing the Patient Authorization on the Enrollment Form, I authorize Providers to use and disclose my Health Information and Identifying Information to Galderma, its affiliates, agents, and service providers, including patient support program service providers, (collectively, "Galderma") in connection with my participation in Galderma Patient Services for NEMLUVIO. Galderma may use my Health Information and/or Personal Information to provide me with various support services and information to help me access NEMLUVIO from Galderma including one or more of the following Galderma services (the "Services"):

1. Work with my insurance to identify eligibility/requirements and attempt to secure coverage for NEMLUVIO,
2. Assist with access including appeals, savings, educational, and support services and information associated with my therapy,
3. Enroll me into appropriate programs that help me gain access to NEMLUVIO, which was prescribed by my healthcare provider,
4. Participate in quality assurance activities such as surveys and feedback related to the Services or my treatment.

By signing this Authorization, my Providers may also disclose my Health Information and Identifying Information to Galderma so that Galderma may use it to help improve, develop, and evaluate Galderma Patient Services for NEMLUVIO, the Services, and other products, services, materials, and programs related to my condition or treatment.

In delivering the Services, Galderma may disclose my Health Information and Identifying Information to my Providers and certain financial assistance programs that may assist with my NEMLUVIO therapy payments. I understand Galderma and Providers may combine my records and information with information and data collected from other sources and use that aggregated information for the purposes listed above. I understand that my Providers may receive payment from Galderma for the use and disclosure of my Health Information/Identifying Information pursuant to this authorization and providing certain Services, such as but not limited to treatment reminders or training, based on my enrollment or participation.

Once I authorize the release of my records and information, I understand it may be redisclosed by the recipient and it may no longer be protected by federal or state health privacy laws or other applicable data protection laws or regulations.

I understand that this Authorization is voluntary and that I do not have to sign it to get treatment or for eligibility or enrollment in benefits from my Providers. I understand that my information will be used by Galderma in accordance with its privacy policy, located at https://www.galderma.com/us/your-privacy. I understand that I can revoke this Authorization at any time by calling 1-855-636-5884 or writing to GaldermaPatientServices@Eversana.com. I understand that I am entitled to receive a copy of this authorization after I sign it.

This Authorization will expire 5 years after I sign it, or earlier if required by law, unless I revoke it sooner. If this Authorization expires or is revoked, it will not impact my Providers' treatment or my insurance benefits. I also understand that if a Provider is disclosing my Health Information to Galderma on an authorized, ongoing basis, my revocation of this Authorization will be effective with respect to that Provider as soon as that Provider receives notice of my revocation. Revocation of this Authorization will not affect prior uses or disclosures of my Health Information.

Galderma Communications Consent

By checking the box on the GPS for NEMLUVIO Enrollment Form, I consent to the use by Galderma of my health and personal information to contact me and provide me with information, marketing materials, and clinical trial opportunities related to my condition or treatment and other information and offers that Galderma believes to be of interest to me. Galderma may contact me for these purposes by e-mail, mail, telephone, and if I have checked the "Text Message Consent" box on the Enrollment Form, pre-recorded or automated calls and texts.

I understand that I can review Galderma's privacy policy, available at https://www.galderma.com/us/your-privacy, for more information about Galderma's collection, use, and sharing of health and personal information. This consent will remain in effect until I cancel it. I understand that I may revoke this consent at any time, which I may do by calling 1-855-636-5884 or writing to GaldermaPatientServices@Eversana.com, and that if I revoke this consent, my revocation will not affect any actions taken by Galderma before receiving my revocation. I may request a copy of this consent. I understand that consent is not required for enrollment in the GPS for NEMLUVIO program.

Text Message Consent

By checking the box on the GPS for NEMLUVIO Enrollment Form, I consent to receive calls and texts from and on behalf of Galderma made with an auto dialer or prerecorded voice, including texts and calls for marketing and promotional purposes, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase or enrollment in the GPS for NEMLUVIO program. The number of messages will vary based on my program selections, and I may receive up to 5 per week. I also understand that message and data rates may apply and that I can text STOP to opt out and HELP for help. I agree to Galderma's Text Messaging Terms, available at https://www.galdermaps.com/gps-sms-terms-and-conditions.

Galderma Patient Services for NEMLUVIO General Terms & Conditions

Galderma Laboratories, L. P. ("Galderma") is the authorized U.S. distributor of the NEMLUVIO® (nemolizumab) for injection. The GPS for NEMLUVIO Program ("Program") is operated by Galderma and its designated service provider(s). The purpose of the Program is to help ensure that eligible patients who have been prescribed NEMLUVIO have access and support related to their NEMLUVIO treatment journey. These General Terms & Conditions are

applicable to any and all of the services provided by Program, including, without limitation, the GPS for NEMLUVIO Quick Start Program, the GPS for NEMLUVIO Bridge Program, the GPS for NEMLUVIO Patient Assistance Program, the GPS for NEMLUVIO Replacement Program, and the GPS for NEMLUVIO Commercial Copay Program, and/or any and all other services provided by the Program.

By participating in and/or receiving any services from any part of the Program, you agree to all of these General Terms & Conditions and any applicable Additional Terms & Conditions. By participating in and/or receiving services from any part of the Program (e.g., GPS for NEMLUVIO Quick Start Program, GPS for NEMLUVIO Bridge Program, GPS for NEMLUVIO Patient Assistance Program, GPS for NEMLUVIO Replacement Program, and/or GPS for NEMLUVIO Commercial Copay Program), you also agree to the Additional Terms & Conditions that apply to each of these programs.

A patient may participate in the Program by enrolling online, contacting GPS for NEMLUVIO directly, or by enrolling with the assistance of their legal representative, healthcare provider ("HCP"), or specialty pharmacy. All services provided by the Program are provided free of charge to eligible patients by Galderma. I understand that my health care providers, pharmacies and health insurers, and their service providers may receive payment from Galderma for providing certain Services, such as but not limited to treatment reminders or training, based on my enrollment or participation.

Patients using NEMLUVIO are not required to enroll in the Program but must enroll if they wish to participate in and/or receive services from the Program. Patients may participate in the Program without signing a Patient Authorization and marketing or text message consent; however, services available to such patients are different.

To participate in and/or receive services from the Program, a patient must be:

- prescribed NEMLUVIO by a licensed US HCP;
- prescribed NEMLUVIO in accordance with its FDA-approved indication(s) and labeling;
- 18 years or older (for patients with prurigo nodularis) or 12 or older (for patients with atopic dermatitis);
- And reside in the 50 United States or Washington DC.

In addition:

NEMLUVIO provided through the Program must not be billed to or have payment requested from any insurance provider or third-party plan, except as permitted in connection with the GPS for NEMLUVIO Copay Program;

- Patients who receive NEMLUVIO through the Program must not sell or transfer NEMLUVIO to any third party;
- Participation in the Program is not conditioned on any past, present, or future purchases or prescriptions, including any potential future fills of NEMLUVIO; and
- Participation is void where prohibited by law.

By participating in the Program, you agree that HCPs, pharmacies and health insurers, and their service providers (collectively, "Providers") may disclose information about a Patient including information such as name, address, and date of birth ("Personal Information") to Galderma and its affiliates, agents, and service providers, including patient support program service providers, (collectively, "Galderma") in connection with my participation in the Program. Patients also agree that any information collected through and/or related to your participation in one or more parts of the Program may be collected, stored, aggregated, used, and disclosed by Galderma for any purpose.

Patient agrees that Galderma may use their Personal Information in a manner in accordance with the terms of the privacy policy at Your Privacy | Galderma US including to provide the patient with various support services and information and to help improve, develop, audit, and evaluate the Program, its services, and other products, services, materials, and programs related to Patient's condition or treatment. Patient understands and agrees that Galderma may combine their records and information with information and data collected about other participants and from other sources and use that aggregated information for a variety of purposes. Additionally, by participating in the Program, health information and personal information will be collected, used, and disclosed by the Program consistent with the Program's service provider's Notice of Privacy Practices, available at https://www.eversana.com/legal/hipaa-practices/.

Acceptance and participation in the Program constitute an agreement with Galderma in Texas. Patient (You) consents to the Program being governed by and interpreted in accordance with the substantive laws of the State of Texas without regard to its conflict of law principles. By enrolling in and/or participating in the Program, Patient agrees that the services have a reasonable relationship to the State of Texas in that, among other things, and agree that the exclusive venue for any dispute arising out of participation in the Program is a state or a federal court of competent jurisdiction in Dallas County, Texas. By enrolling in and/or participating in the Program, you irrevocably and unconditionally submit to the exclusive jurisdiction of a state or a federal court in Dallas County, Texas.

Not all patients will be eligible for all or any services provided in the Program. Offers and services provided under the Program may not be the best offer or lowest cost service available to you. Participation in one or more services of the Program may be subject to limitations imposed by your health insurer, and state or federal law. Galderma reserves the right to modify, rescind, or discontinue this Program, any part(s) or service(s) provided under the Program, the Terms & Conditions of the Program, and the Additional Terms & Conditions of its services at any time without notification and for any reason. Galderma reserves the right to rescind or revoke a patient's participation in the Program and its service(s) at any time and for any reason including noncompliance with the General and/or Additional Terms & Conditions or Terms & Conditions suspected fraud. Galderma may communicate changes to patients and their Providers by periodically updating the GPS for NEMLUVIO General Terms & Conditions and/or Additional Terms & Conditions which are available online.

To unenroll in the GPS for NEMLUVIO Program, call 1-855-636-5884 for further instructions. You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.FDA.gov/MEDWatch or Call 1-800-FDA-1088 or call Galderma Special Services at 866-735-4137.

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Additional Terms & Conditions for the GPS for NEMLUVIO Commercial Copay Program

The GPS for NEMLUVIO Copay Program may provide financial support for certain commercially insured nemolizumab patients ("eligible patients"). In addition to the General Terms & Conditions, by enrolling in and/or participating in the GPS for NEMLUVIO Copay Program additional terms & conditions apply. For full terms and conditions of the Commercial Copay Program visit https://www.galdermaps.com/terms-and-conditions or contact GPS.

THE GPS FOR NEMLUVIO COMMERCIAL COPAY PROGRAM IS NOT INSURANCE.

Additional Terms & Conditions of the GPS for NEMLUVIO Quick Start Program

In addition to the GPS for NEMLUVIO General Terms and Conditions, by enrolling in and/or participating in the GPS for NEMLUVIO Quick Start Program these additional Terms & Conditions apply. The GPS for NEMLUVIO Quick Start Program is provided to eligible commercially insured patients, who meet all of the below criteria so that they may begin treatment quickly and may start improving their skin story:

- Patient must have commercial insurance that requires prior authorization for NEMLUVIO from Galderma
- The patient must not have prescription drug coverage for the product, in whole or in part under federal or state health care program, including but not limited to Medicare or Medicaid
- Patient's prescribing HCP must continue to pursue coverage through the patient's insurance while the patient is receiving treatment through the GPS for NEMLUVIO Quick Start Program
- Patients who have been initiated on therapy using samples are eligible for the GPS for NEMLUVIO Quick Start Program
- Patients may not have previously participated in the GPS for NEMLUVIO Quick Start Program for NEMLUVIO.

Patients enrolled in the GPS for NEMLUVIO Quick Start Program may receive up to an initial loading dose and two subsequent dosages of NEMLUVIO, as prescribed by their HCP and consistent with labelling. The eligibility guidelines for the Quick Start Program may change at any time.

THE GPS FOR NEMLUVIO QUICK START PROGRAM IS NOT INSURANCE.

GPS for NEMLUVIO Bridge Program Terms & Conditions

In addition to the GPS for NEMLUVIO General Terms and Conditions, by enrolling in and/or participating in the Bridge Program these additional Terms & Conditions apply. The GPS for NEMLUVIO Bridge Program is provided to eligible patients who meet the below criteria so that they may continue NEMLUVIO while insurance barriers are resolved. Eligible Patients for the GPS for NEMLUVIO Bridge Program must meet all of the following criteria:

- Patients must have insurance
- The patient must experience a delay in coverage determination, which may be (i) a prior authorization delay that will cause a patient to miss dose(s); (ii) upon a change of insurance, (iii) an insurance or prior authorization denial for which an appeal has been submitted, or (iv) a delay due to coverage not yet established by the patient's plan when the product is new to market.
- Patient's prescribing HCP must continue to pursue coverage through the patient's insurance while the patient is receiving treatment through the GPS for NEMLUVIO Bridge Program

Patients enrolled in the GPS for NEMLUVIO Bridge Program may receive up to 2 years of NEMLUVIO if they continue to qualify. The eligibility guidelines for the Bridge Program may change at any time.

THE GPS FOR NEMLUVIO BRIDGE PROGRAM IS NOT INSURANCE.

GPS for NEMLUVIO Replacement Program Terms & Conditions

In addition to the GPS for NEMLUVIO General Terms and Conditions, by enrolling in and/or participating in the GPS for NEMLUVIO Replacement Program, GPS for NEMLUVIO Replacement Program Additional Terms & Conditions will apply. (Full terms and conditions can be found at https://www.galdermaps.com/terms-and-conditions or contact GPS.) Galderma reserves the sole right to determine whether product should be replaced and whether a patient is eligible to participate in the GPS for NEMLUVIO Replacement Program.

GPS for NEMLUVIO Injection Education & Training Program Additional Terms and Conditions

In addition to the GPS for NEMLUVIO General Terms and Conditions, by enrolling in and/or participating in the Injection Education & Training Program these GPS for NEMLUVIO Injection Education & Training Program Additional Terms & Conditions apply. Patient agrees that GPS for NEMLUVIO can provide injection education and training but under no circumstances will injections be provided, as this program only provides training. Patient acknowledges that the services provided are not medical advice, and that any personnel providing services under GPS for NEMLUVIO are not your healthcare provider. Patient should consult their healthcare provider if they have questions about their therapy or condition.

Participation in this program is voluntary and patient may decline this service at any time. Patient agrees to receive communications related to scheduling and confirmation of appointments. Patient agrees to provide a safe environment to access for training. Galderma reserves the right to reschedule or decline to provide services in our discretion. Patient will not submit claims for training to their insurance provider.